

# Innovative Models of Care (IMOC) Program – Connected Communities Project

Amity Health will deliver the Albany Connected Communities Project: a social prescribing model where health professionals refer patients with unmet social needs to a connect team which then refers patients on to existing support services.

**Round 5: Amity Health** Connected Communities Project

**Location:** Albany, Western Australia (MM3)

**Funding:** \$1.5 million over 4 years from 2024

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The activity tests a social prescribing model where health professionals refer patients with unmet social need to a connect team. The connect team will assess patients functional and social needs and refer them to existing community services, support groups, and social groups that assist them better manage their health, meet their social needs, and achieve their life goals. The model will prioritise patients over 65 years, and/or those experiencing chronic illness or illness responsive to lifestyle modification.

In the short-term, the project aims to support individuals to play a stronger role in self-managing their health and mobilise communities to be more engaged and equipped to offer support. In the long-term, the approach aims to address the social determinants of health and create better community-wide health, social, emotional and wellbeing outcomes. The culmination of these aims to reduce demand from primary care, improve access and reduce health costs.

The funding will support the staffing of the connect team, specifically the link worker, project manager, strategic oversight clinician and data support to enable the team to link community members with existing community services, support groups and other social groups that can assist them better manage their health, meet their social needs, and achieve their life goals. The Project has three objectives:

1. Support Albany develop and embed an innovative model of care that bridges health and social need to provide wholistic, patient-centred, primary health care.
2. Support the development of strong local relationships that facilitate collaborative multidisciplinary teams.
3. Build an evidence base that defines the value of coordinated health and social care in supporting patient health and wellbeing.

The activity will also include:

- the delivery of at least four community co-design sessions that enable all relevant community stakeholders to input on the model, including community service organisations, local governance groups, potential participants, and local health organisations.

- delivery of comprehensive consultation report that details all findings from community consultation and outlines the details of the final co-designed model.
- delivery of a comprehensive pack project material that includes co-designed referral pathways, referral forms, referral feedback loops, patient information sheets, participation consent sheets, map of community assets, intake and assessment screening, and initial advertising/promotion material.

The evaluation framework will be delivered by November 2024 and implemented from January 2025 and will be used to assess the program outcomes all measured from a baseline status determined early in the project.

